New York City Department of Education
Division of Human Resources
65 Court Street • Brooklyn, New York 11201

Request for Leave under the Family and Medical Leave Act (FMLA)
(For Administrative and Pedagogical Staff)

FMLA leaves may be approved at the local level by the organization head. Applications may be referred to the Division of Human Resources, Medical, Leaves, and Benefits Office for clarification, where necessary.

Any paid leave for a FMLA qualifying reason, will be counted against annual FMLA leave entitlements.

Employees must provide acceptable certification by a physician or other health care provider for their own serious health condition or the serious health condition of a covered family member within fifteen (15) calendar days of the request for leave, where practicable. Leave may be denied if such documentation is not provided. Certification of fitness to return to work may be required. Employees requesting intermittent leave or leave on a reduced leave schedule which is medically necessary must advise their responsibility center or school, upon request, of the reasons the intermittent/reduced leave schedule is necessary and of the schedule for treatment, if applicable. The employee and the responsibility center or school must attempt to work out a schedule, which meets the employee's needs without unduly disrupting the operations of the organization.

Employees requesting child care leave must provide proof that the child is under one (1) year old. Legal documentation must be attached for employees requesting leave for the placement of a child for adoption or foster care. Documentation should be provided within fifteen (15) calendar days of the request for leave, where practicable. The leave may be denied if such documentation is not provided.

Employees are entitled to restoration to the same or an equivalent position upon return from FMLA leave.

Employees' health coverage will be maintained during approved FMLA leave. Employees must pay the premiums for any optional riders. Premiums paid by the City during the period of unpaid leave may be recovered if the employee fails to return to work. Form EB-1054, Health Benefits Report/Inquiry, must be filed by the responsibility center/school with the Medical, Leaves, and Benefits Office, 65 Court Street, Brooklyn, New York 11201. Documentation indicating that the leave has been approved must be attached.

Please consult Personnel Memorandum No. 54, 1995-1996 for further information.

SECTION I - TO BE COMPLETED BY THE EMPLOYEE

_____ _____/____/_____ _____
Employee's Name Social Security Number EIS #

Civil Service Title or Pedagogical License _____

Civil Service Status: _____Hourly _____Annual Pedagogical Status: _____Full-Time _____ Regular Sub.

Work Location: _____ (____)_____
Division/Bureau/School Telephone Number

Work Address: _____
Street City State Zip Code

Date of commencement of Leave: ____/____/____ Probable date of return to work: ____/____/____
Date employee goes off payroll ____/____/____

I AM REQUESTING LEAVE FOR: (check one)

1. ____Child care due to: (check one)
   ☐ Birth of child ☐ Placement of child for adoption ☐ Placement of child for foster care
2. ____ Maternity Related Disability
3. ____ Care of seriously ill: (check one) ☐ spouse ☐ parent ☐ child
4. ____ Own serious health condition that makes the employee unable to perform his/her job functions (all paid sick leave must first be exhausted).

   For items 3 & 4: ☐ Check here if intermittent leave is being requested

EMPLOYEE CERTIFICATIONS

CHILD CARE LEAVE CERTIFICATION

I, _____ , am the parent or legal guardian of (circle one)
Name of Employee

(a). a child born, (b). a child placed for adoption, or (c). a child placed for foster care on _____.
Date of Birth or Placement

Note: A copy of the birth certificate; physician's or other health care provider's letter; attorney's letter; letter from an adoption agency or the appropriate State agency; or other appropriate documentation attesting to the fact and date of birth or placement of the child must be attached. Child care leave taken under the Family Medical Leave Act must be concluded within 12 months after the birth, placement for adoption, or placement for foster care of the child.

_____
Employee's Signature **Date**

PLEASE CONTINUE ON REVERSE SIDE

CERTIFICATION FOR EMPLOYEE TO CARE FOR SERIOUSLY ILL FAMILY MEMBER

Please state the care you will provide and an estimate of the time period during which this care will be provided including a schedule if the leave is to be taken intermittently or on a reduced leave schedule:

_____

_____

_____

_____
Employee's Signature **Date**

SECTION II - PHYSICIAN OR OTHER RELATED HEALTH CARE PROVIDER CERTIFICATION

1. Employee's Name: _____ SS#: ___/___/___

2. Patient's Name (if other than employee): _____

3. Diagnosis: _____

_____

_____

Date condition commenced: ___/___/___ Probable duration: ___/___/___ to ___/___/___

4. Regimen of treatment to be prescribed (indicate below number of visits, general nature and duration of treatment, including referral to other provider of health care services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

(a). By Physician or Health Care Provider: _____

_____

_____

(b). By another provider of health care services, if referred by a physician or other Health Care Provider: _____

_____

_____

IF THIS CERTIFICATION RELATES TO CARE FOR AN EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 5 – 7 AND CONTINUE WITH ITEM 8.

5. Is inpatient hospitalization of the employee required? ☐ YES ☐ NO

6. Is employee able to perform work of any kind? (if No, skip item 7) ☐ YES ☐ NO

7. Is employee able to perform the functions of his/her position? ☐ YES ☐ NO

8. Is inpatient hospitalization of the family member (patient) required? ☐ YES ☐ NO

9. Does (or will) patient require assistance for basic medical, hygiene, nutritional, safety or transportation needs? ☐ YES ☐ NO

10. After review of the employee's signed statement (Certification Statement in Section I), is the employee's presence necessary or would it be beneficial to the patient? (This may include psychological comfort.) ☐ YES ☐ NO

11. Estimate the period of time the employee's care is needed or would be beneficial: _____

_____ _____
Signature of Physician or other Health Care Provider **Date**

_____ _____
Title of other Health Care Provider (if applicable) **Type of Practice (field of specialization, if any)**

_____ _____
Employee's Signature **Date** **Supervisor/Principal's Signature** **Date**

_____ _____
Timekeeper/Payroll Secretary's Signature **Date** **Superintendent's Signature** **Date**

SECTION III - FOR DIVISION OF HUMAN RESOURCES USE ONLY

☐ APPROVED ☐ DENIED

COMMENTS: _____

_____ _____ _____
NAME (Please Print) **SIGNATURE** **DATE**